

CANADA / JUDGMENT

Hobbs v. Robertson

2004 BCSC 1088

COURT

Supreme Court of British Columbia

DECIDED

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2004 BCSC 1088 Hobbs v. Robertson

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Hobbs v. Robertson,

2004 BCSC 1088

Date: 20040816

Docket: C980582

Registry: Vancouver

Between:

Ernest Hobbs, on his own behalf and

Ernest Hobbs as guardian ad litem for Kaleb Hobbs,

Travis Hobbs, also known as Travis Redlack and

Jada Hobbs, also known as Jada Redlack

Plaintiffs

And

Dr. John G.M. Robertson

Defendant

Before: The Honourable Mr. Justice Pitfield

Reasons for Judgment

Counsel for the Plaintiffs:

L.J. Zivot

D. Dahlgren

S. Brady

Counsel for the Defendant:

P.M. Willcock

Dates and Place of Trial:

July 12-15, 2004

Vancouver, B.C.

Introduction

- [1] Mrs. Daphine Hobbs, one of Jehovah's Witnesses, died on April 16, 1996, as a consequence of massive blood loss sustained in the course of a hysterectomy surgery. She was 35 years of age. Her surviving husband and three infant children bring this action under s. 2 of the Family Compensation Act, R.S.B.C. 1996, c. 126 which provides as follows:
2. If the death of a person is caused by wrongful act, neglect or default, and the act, neglect or default is such as would, if death had not resulted, have entitled the party injured to maintain an action and recover damages for it, any person, partnership or corporation which would have been liable if death had not resulted is liable in an action for damages, despite the death of the person injured, and although the death has been caused under circumstances that amount in law to an indictable offence.
- [2] The issue in the action is the extent to which the plaintiffs' claim for compensation is affected by a document entitled "Refusal to Permit Blood Transfusion" signed by Mrs. Hobbs, the effect of which was to deny medical practitioners the opportunity to transfuse Mrs. Hobbs with blood or blood products that would have saved her life.
- [3] As originally framed, the action named Dr. Robertson, other doctors involved with the care of Mrs. Hobbs on April 15 and 16, 1996, and the Chilliwack General Hospital Society as defendants. The action was discontinued without costs as against all defendants other than Dr. Robertson, a specialist in obstetrics and gynaecology.
- [4] This is the second trial of the action. The first proceeded before Melvin J. pursuant to Rule 18A of the Rules of Court on the basis of affidavits and certain assumptions, rather than findings or admissions, of fact: see (2001), 85 B.C.L.R. (3d) 114, 2001 BCSC 162. The learned trial judge held that the document signed by Mrs. Hobbs did not bar the recovery of damages for negligence. As a result, he dismissed the defendant's Rule 18A application seeking dismissal of the plaintiffs' action. The Court of Appeal set aside the trial judgment and ordered a new trial: see (2002), 172 B.C.A.C. 282, 2002 BCCA 381. The basis for the Court's decision is set forth in paragraphs 4 through 6 of its reasons as follows:

¶4 In this court, the defendants deny any intention on their part to admit negligence in any form, and attack each of the Chambers judge's conclusions. They say the Chambers judge was wrong to conclude that "[t]he need for the precluded remedial step was created" by the defendants' initial negligence and that counsel had not intended to "characterize the cause of blood loss." Each of their grounds of appeal creates almost insurmountable difficulties due to the absence of specific findings of fact as to the defendants' assumed negligence. Did it consist in doing something that caused Mrs. Hobbs to bleed copiously, or in not taking particular preventative or remedial measures, or in some other act or omission? Without the answers to these questions, the scope of the Chambers judge's ruling that the release does not bar the action is unclear and the issues on appeal may not be analyzed in any nuanced way. The respondents may argue that if the appeal is allowed, doctors performing surgery on Jehovah's Witness patients have complete immunity from liability for the consequence of carelessness, if injury or death could have been avoided by transfusion. Yet allowing the appeal might mean only that such doctors have no liability for failing to do that which the patient has prohibited them from doing. On the other hand, the appellants may argue that if the appeal is dismissed, the consequence will be that no release will ever be given effect to where a tension arises between the patient's freedom of religion and her need for medical care. Yet dismissing the appeal might mean only that the wording of this release was inapt to excuse the doctors from responsibility for carelessness in causing the bleeding, if that proves to be what in fact occurred.

¶5 A similar difficulty arises from the Chambers judge's assumption that carelessness on the defendant's part "caused" (in the legal sense) Mrs. Hobbs' bleeding. As indicated above, he was not asked to assume that very important fact, which may well be the central question to be decided at trial.

¶6 The point is that until it becomes clear, as a factual matter, of what the defendants' negligence consisted, the scope and consequence of the appeal would be largely speculative, and indeed the appeal might turn out to be entirely moot. That is not, in my respectful view, a proper use of Rule 18A.

[emphasis in original]

[5] I have had the benefit of evidence and admissions of fact not available to Melvin J. I have also had the benefit of submissions with respect to the nature and meaning of the Refusal that do not appear to have been made in the earlier trial. For those reasons, and the fact the Court of Appeal ordered a new trial, I do not consider myself constrained, on the basis of stare decisis, by the conclusions reached by Melvin J. in the event I should conclude that I must differ with him in the result.

Findings of Fact

[6] All material facts were admitted at the retrial. No viva voce evidence was called. The facts, in the context of which the case must be decided, are the following.

- [7] Mrs. Hobbs was referred by her family physician to Dr. Robertson who saw her on January 25, 1996. She complained to him of heavy, irregular periods, pelvic pain and tenderness over a period of one year.
- [8] Dr. Robertson discussed medical, non-surgical, options to control her menstrual bleeding. Mrs. Hobbs declined the medical options because some of them had not been effective for her in the past.
- [9] Dr. Robertson discussed surgical options with Mrs. Hobbs. These included dilation and curettage, endometrial ablation or surgical destruction of the endometrial lining of the uterus, and hysterectomy.
- [10] The parties admit that Dr. Robertson's usual practice was to explain that endometrial ablation was day surgery, 20% to 40% of women never have another period after endometrial ablation, 40% to 60% of women have periods that are lighter and shorter after endometrial ablation, and about 20% of women are unhappy with the amount of bleeding they have long term after such surgery. The parties admit that Dr. Robertson told Mrs. Hobbs that the risks associated with endometrial ablation were less than those associated with hysterectomy.
- [11] Mrs. Hobbs told Dr. Robertson that two of her sisters underwent hysterectomies for similar problems and therefore she felt she should also have a hysterectomy.
- [12] Dr. Robertson was aware that Mrs. Hobbs had previously undergone a caesarean section and a tubal ligation. He told Mrs. Hobbs that a vaginal hysterectomy was not an option for her because of the likelihood of scarring and adhesions from the earlier caesarean section. He told Mrs. Hobbs that the risk of bleeding and infection were increased with a laparoscopically-assisted vaginal hysterectomy (LAVH) compared to an abdominal hysterectomy.
- [13] Following her discussion with Dr. Robertson, Mrs. Hobbs elected to undergo a LAVH. Between 1994 and the death of Ms. Hobbs on April 16, 1996, Dr. Robertson had performed the LAVH procedure between 10 and 20 times. He had performed between 20 and 30 vaginal hysterectomies and approximately 30 abdominal hysterectomies.
- [14] Soon after January 25, 1996, Dr. Robertson booked Mrs. Hobbs for the LAVH procedure which was expected to last a total of 2.6 hours or 160 minutes.
- [15] On February 20, 1996, Mrs. Hobbs saw Dr. Robertson on her own initiative because she had questions with respect to the proposed surgery. Dr. Robertson discussed the surgery and post-operative recovery with Mrs. Hobbs. He believed that she left feeling better about her surgery. He gave her a booklet entitled "Understanding hysterectomy - a guide for patients and their families" which described the procedure. He invited Mrs. Hobbs to return to further discuss the procedure if she wished to do so.
- [16] The booklet described a hysterectomy in the following terms:

First: You're about to undergo one of the most common - and thus one of the best understood - of all inpatient procedures. Each year, in fact, about 60,000 Canadian women have a hysterectomy. Operative techniques and aftercare treatments have been perfected over the course of a century, while more recent advances in antibiotics and anaesthetics have all helped too.

Second: As performed today in a modern hospital, hysterectomy is one of the safer major procedures.

Third: Hysterectomy works. By effectively relieving uncontrollable bleeding and intolerable pain, this type of surgery has improved the lives of thousands of women.

[emphasis in the original]

[17] The booklet described alternative hysterectomy techniques in the following terms:

Vaginal hysterectomy

About one in four hysterectomies are [sic] performed with removal of the uterus through the vagina. There's no abdominal incision, no scar, less pain and you'll return home more quickly. Furthermore, the ovaries are usually left intact.

Laparoscopically-assisted vaginal hysterectomy

This is a relatively new technique which uses the laparoscope, a device like a very small lighted telescope. With the help of a laparoscope and tiny incisions in the abdomen near the navel the doctor detaches the uterus and then removes it through the vagina. Thanks to the laparoscope, the doctor gets a good view of the uterus and also has better control over the surgery than if the whole operation were performed vaginally. There is no major abdominal incision, less pain and as in the vaginal procedure, you should return home more quickly. Today more and more doctors are being trained in this technique.

Traditional abdominal hysterectomy

Most hysterectomies are performed this way; the doctor removes the uterus via an incision about six to eight inches along the abdomen. The doctor may use a "bikini" (horizontal) cut, just across the top of the pubic hair, or a vertical cut just above the pubic bone.

[18] Dr. Robertson was aware that Mrs. Hobbs was one of Jehovah's Witnesses. He was aware that she did not want any blood transfusions or blood products. Mrs. Hobbs had been referred to him for care in 1994 because of complications surrounding her pregnancy that resulted in a successful delivery by caesarean section. His consultation report dated August 8, 1994 records the following:

I do note that she is a Jehovah's Witness and that we will have to be aware of this during the course of her management.

- [19] Dr. Robertson's clinical notes of January 15, 1996 recorded the notation "no blood". His reporting letter of the same date to the referring physician noted that "she is a Jehovah's Witness and does not want any blood transfusions or blood products".
- [20] Dr. Robertson acknowledged that he wanted to choose a procedure that minimized the risk of bleeding when operating on a patient who advised him that she would not accept a transfusion of blood or blood products. This notwithstanding, the plaintiffs do not suggest that Dr. Robertson was negligent in agreeing to Mrs. Hobbs' decision to undergo the LAVH procedure rather than an abdominal hysterectomy although the latter was likely to result in less blood loss. Dr. Robertson was aware that regardless of the hysterectomy technique chosen, when confronted with uncontrolled bleeding, the abdominal approach was the approach of first choice because it gave the surgeon the best opportunity to see and suture bleeding vessels.
- [21] On April 12, 1996, Mrs. Hobbs attended at a pre-assessment clinic at Chilliwack General Hospital where she signed the Refusal. A nurse was the only medical person Mrs. Hobbs saw on that date.
- [22] The Refusal signed by Mrs. Hobbs was identical to that signed by her on four admissions to the Chilliwack General Hospital in 1994. The document signed April 12, 1996, read as follows:

I request that no blood or blood derivatives be administered to myself, Daphne L. Hobbs, during this hospitalization. I hereby release the CHILLIWACK GENERAL HOSPITAL, its agents and personnel, and the attending doctors from any responsibility whatsoever for unfavourable reactions or complications or any untoward results, which may include death, due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

- [23] The Chilliwack Hospital requires persons who choose not to accept blood or blood products to sign the refusal at or before their admission. All of Jehovah's Witnesses admitted as patients to the hospital must sign the refusal if they adhere to the religious tenets of their faith, one of which is a Biblical direction to 'abstain from blood'.
- [24] The parties admit that Mr. Hobbs, the husband of the deceased, understood that a patient who objected to receiving a blood transfusion during hospitalization at the Chilliwack General Hospital would have to sign a form which included a release of claims arising out of the refusal to accept a blood transfusion. In fact, Mr. Hobbs himself had signed such a form when he had undergone an operation at the hospital on an earlier date.
- [25] Dr. Robertson was not involved in the preparation or signing of the refusal. He did not discuss the document or its legal effect with Mrs. Hobbs. He was not aware whether or not she had signed the form. Neither he, nor any other doctor or hospital employee advised Mrs. Hobbs of the action they would take if she did not sign the Refusal. Dr. Robertson was not aware of any physician at the Chilliwack Hospital who would refrain from performing

surgery on a patient who would not sign the Hospital's form of refusal to permit blood transfusion.

- [26] Mrs. Hobbs was admitted to the Chilliwack General Hospital at 1045 hours on April 15, 1996. She walked to the pre-operative holding area at 1135 hours. Some time between 1135 and 1205 hours, Dr. A.A. Suleman, an anaesthetist, saw from the anaesthesia record that Mrs. Hobbs had signed the Refusal. Dr. Robertson had not told Dr. Suleman that Mrs. Hobbs was one of Jehovah's Witnesses who would not consent to a blood transfusion.
- [27] Dr. Suleman spoke for the first and only time with Mrs. Hobbs in the pre-operative holding area. They spoke for approximately ten minutes. Dr. Suleman recorded the fact that Mrs. Hobbs had signed the refusal on the chart.
- [28] Dr. Suleman's usual practice was to advise a patient, and he so advised Mrs. Hobbs, that the procedure she was to undergo would entail blood loss. He advised that the exact amount of the loss could vary and could not be determined until surgery was underway. He advised it could be minimal or it could be excessive. He advised Mrs. Hobbs that if there were excessive blood loss and it could not be replaced, she would run the risk of arrhythmias, heart attack, congestive heart failure or pulmonary edema. He advised her that she might require ventilation post-operatively and she could die.
- [29] Dr. Suleman recalls discussing red blood cells, white blood cells, plasma and platelets, and clotting factors with Mrs. Hobbs. He says he told her that when one bleeds one loses red and white blood cells, platelets and plasma, and that this entails loss of clotting factors.
- [30] Dr. Suleman discussed with Mrs. Hobbs the possibility of giving her crystalloids and colloids to temporarily replace the volume of blood lost in the event of excessive bleeding. He also told her that crystalloids and colloids would not replace the red blood cells and the blood components that she might need to stay alive.
- [31] Dr. Suleman recalled that Mrs. Hobbs told him she was willing to undergo the surgery despite the risks that he had described to her and under no circumstances was she to receive blood or blood products.
- [32] Dr. Robertson commenced the surgery at 1218 hours on April 15, 1996. At that time, Mrs. Hobbs' vital signs and blood levels were normal. Dr. Robertson proceeded laparoscopically to 1345 hours at which point he decided that the hysterectomy should be finished vaginally. He explained the change in procedure as follows:

The right round ligament was cauterized and cut. The right fallopian tube was cauterized and cut and the ovarian pedicle was cauterized and cut. Dissection was carried down; however, it became more difficult, because of the previous scarring from her cesarean [sic] section, to get at the ligaments adequately. A bladder flap was created anteriorly to dissect the bladder off the uterus and the adhesions were freed up as much as possible.

It was decided at this point in time that the hysterectomy should be finished vaginally.

[33] Dr. Robertson abandoned the vaginal approach to the hysterectomy in favour of an abdominal approach at 1520 hours. His operative notes record the reason for the change to an abdominal approach as follows:

At this point in time, there was a large amount of bleeding and the site of the bleeding could not be easily ascertained. It was therefore decided that the approach should be switched to an abdominal approach.

[34] The abdominal procedure was completed at 1635 hours. Dr. Robertson described his observations in respect of the abdominal procedure in his operative note as follows:

There was a moderate amount of blood and clot present in the pelvis and this was removed. The surgical site was identified and there was bleeding coming from the vaginal vault cuff and this was oversewn. There was bleeding coming from the right angle of the vaginal vault and there were two obvious vessels that were clamped and oversewn.

...

At this point in time, there was a great deal of concern about the patient's blood pressure and vital signs and she was resuscitated with [crystalloid].

[35] Dr. Suleman was the attending anaesthetist throughout the procedure. At 1345 hours, he observed a sharp rise in Mrs. Hobbs' pulse rate, indicating she was bleeding and that her heart was beating faster to compensate for blood loss and dilutional anaemia. Dr. Suleman became concerned about blood loss and attached a second intravenous line to maintain her blood pressure and volume. He told Dr. Robertson that he was starting another blood line for ongoing blood loss.

[36] Some time between 1345 and 1430 hours, Dr. Suleman began to tell Dr. Robertson and the surgical team that Mrs. Hobbs was losing blood. He so advised them when he observed she had lost 500 millilitres of blood from the surgical site and again when he observed the blood loss to be 1000 millilitres.

[37] Some time between 1415 and 1430 hours Dr. Suleman left the operating room to obtain a unit of 10 percent Dextran, a colloid solution that can be used as a blood volume replacement. Outside the operating room Dr. Suleman encountered Dr. Undrell, another anaesthetist. When told of Mrs. Hobbs' blood loss, Dr. Undrell recommended that Dr. Robertson convert to an abdominal procedure.

[38] On returning to the operating room, Dr. Suleman and Dr. Robertson discussed the possibility of converting the operation to an open abdominal procedure. Dr. Robertson stated that he felt that he would be able to achieve haemostasis, or the cessation of bleeding, vaginally. Dr. Robertson believed that the vaginal bleeding was slowing down and that he had the blood loss under reasonable control.

- [39] Dr. Suleman decided there was no point in calling for the assistance of a second surgeon because he had been informed by Dr. Robertson that he did not want to convert to an open abdominal hysterectomy at that point.
- [40] At 1430 hours, Dr. Suleman told Dr. Robertson and the surgical team that Mrs. Hobbs had lost 1,700 millilitres of blood. Dr. Suleman was of the view that by that time, Mrs. Hobbs had likely lost more blood that had been absorbed in sponges or collected internally. Dr. Suleman administered the first 500 millilitres of Dextran.
- [41] By 1500 hours, Mrs. Hobbs had lost at least 2,000 millilitres of blood. After 1515 hours, her blood pressure dropped further. Dr. Suleman administered another 500 millilitres of Dextran. To that point, Mrs. Hobbs had received 10 litres of Ringer's lactate and 1,000 millilitres of Dextran, both of which are blood volume substitutes or replacements.
- [42] By 1500 hours, Mrs. Hobbs had lost approximately one-half of her circulating blood volume. The parties admit that her haemoglobin would then have been in the range of 60 to 70 grams per millilitre and her blood would likely have had sufficient oxygen-carrying capacity to permit survival without a transfusion.
- [43] Dr. Suleman says that at some time just prior to converting to an abdominal approach to the surgery, Dr. Robertson remarked that he could not stop the bleeding. Dr. Robertson recalled that shortly before the operation was converted to an open abdominal procedure at approximately 1520 hours, there was a large amount of bleeding from a site which could not be ascertained.
- [44] Dr. Robertson admits the expert evidence that the standard of care in his specialty required that, in the circumstances of this case, the vaginal hysterectomy be converted to an open abdominal procedure not later than 1430 hours. He also admits that the standard of care in his specialty required that, rather than morselating or cutting the uterus into pieces vaginally or laparoscopically, he should have converted the vaginal hysterectomy to an open abdominal procedure.
- [45] The only negligence admitted in this action in relation to bleeding is the omission to convert to an open abdominal procedure not later than 1430 hours.
- [46] Dr. Robertson admits that, on the balance of probabilities, the blood loss would have been stopped and Mrs. Hobbs would have survived without need of a transfusion had abdominal surgery been commenced not later than 1430 hours. He admits that, on the balance of probabilities, the delay in the commencement of abdominal surgery to 1520 hours resulted in the need for transfusion. He admits that the inability to transfuse resulted in Mrs. Hobbs' death.

- [47] Upon completion of the operation at 1635 hours, four hours and seventeen minutes after its commencement, Mrs. Hobbs was moved to the intensive care unit. By that time, she had lost at least 4,000 millilitres of blood. She had received a total of 14 litres of Ringer's solution and 1 litre of Dextran, in aggregate approximately three times her circulating blood volume.
- [48] While Mrs. Hobbs was in the intensive care unit, Dr. A. Richmond, a specialist in intensive care, advised Mr. Hobbs that he was concerned about Mrs. Hobbs' life and that she would die if she did not receive a blood transfusion. Mr. Hobbs advised Dr. Richmond that he could not go against his wife's wishes and religious convictions and therefore he would not consent to the administration of blood transfusions.
- [49] The plaintiffs admit that on the balance of probabilities, a transfusion intra-operatively or post-operatively would have enabled Mrs. Hobbs to survive. The plaintiffs also admit that Mrs. Hobbs' instructions, provided when she was capable, were that she not receive blood transfusions and that those instructions were known by the treating physicians and Mr. Hobbs.
- [50] Mrs. Hobbs was pronounced dead at 0129 hours on April 16, 1996. The death resulted from prolonged tissue hypoxia leading to shock and cardiac failure resulting from massive blood loss. Dr. Richmond described the situation in the following terms in his discharge summary:

In summary, this tragic death was secondary to surgical bleeding and then medical bleeding from lack of coagulation factors. Unfortunately, this is death that could have been prevented if this lady could have received blood and coagulation products.

- [51] The parties agree that surgical bleeding is that resulting from surgical action. Medical bleeding is that resulting from the absence of blood components that cause coagulation and promote the cessation of bleeding.

Issues

- [52] On the basis of the admissions of fact as I have described the parties state the question to be determined as follows:

On the admissions made and the opinions admitted into evidence, is this action in negligence arising out of the death of Daphne Hobbs barred by the release of the attending doctors from any responsibility whatsoever for unfavourable reactions or complications or any untoward results, which may include death, due to Mrs. Hobbs' refusal to permit blood or blood derivatives to be administered to her?

- [53] The plaintiffs respond to the stated question as follows:

- (a) Death was caused or materially contributed to by Dr. Robertson's negligence;
- (b) The Refusal is no force or effect because Mrs. Hobbs received no consideration for it;

- (c) If valid, the Refusal, comprised of the request and release, only constituted a waiver of the liability that would arise in the event Dr. Robertson omitted to transfuse blood or blood products when the standard of medical practice would have required him to do so;
 - (d) The Refusal did not absolve Dr. Robertson of liability for any other kind of negligence;
 - (e) Mrs. Hobbs' request that no blood or blood products be transfused did not result in a voluntary assumption of the risk of medical negligence; and
 - (f) A release that absolves a physician of responsibility for negligence is contrary to public policy.
- [54] The plaintiffs also say that if the Refusal absolved Dr. Robertson of responsibility for any and all negligence on his part, the document contravened Mrs. Hobbs' Charter rights of equality and freedom of religion, and the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the fundamental principles of justice. By agreement between counsel, submissions on any constitutional questions were deferred pending disposition on non-constitutional grounds.
- [55] The defendant responds to the stated question as follows:
- (a) The Refusal was contractually binding on Mrs. Hobbs;
 - (b) The plain meaning of the Refusal was to absolve Dr. Robertson of 'any responsibility whatsoever' in respect of morbidity or death occasioned by the inability to transfuse blood or blood products;
 - (c) The direction and release were not contrary to public policy; and
 - (d) In the alternative, Mrs. Hobbs expressly assumed the physical and legal risk associated with blood loss which could not be treated by transfusion.

Analysis

(a) Consideration

- [56] With respect, the plaintiffs' argument that the Refusal was void for want of consideration must fail. Mrs. Hobbs signed the Refusal three days in advance of surgery. She was aware that document was required by the hospital. She had signed a similar document on four previous occasions. The document she signed stated that she understood the consequences that could flow from her refusal to accept blood. The adverse effects that might be associated with her refusal to accept a transfusion of blood or blood products were fully explained to her by Dr. Suleman before the operation.

- [57] The fact the Refusal was procured by the hospital for its benefit and that of staff and doctors involved in Mrs. Hobbs' care does not detract from its binding effect in so far as Dr. Robertson is concerned. There is no reason why, in the context of the provincial medical system, the hospital cannot procure the Refusal as agent for any personnel, including doctors, involved in providing care.
- [58] The fact that Mrs. Hobbs would not pay for the surgical procedure does not alter the fact that there was a contract between her and the hospital and between her and Dr. Robertson. Coverage under a policy of insurance, whether public or private, does not undermine the contract pursuant to which medical services were provided to her. Rather, insurance was the means by which the financial burden associated with health care was assumed by the insurer rather than the insured.
- [59] In other circumstances, a Jehovah's Witness successfully relied on a request similar to that made by Mrs. Hobbs, but without the accompanying release, to support a claim for damages from battery when a transfusion was provided to her as an unconscious patient in life-threatening circumstances: see *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.). In that case, the court held that the patient's request that was recorded on a card she carried on her person and known to the attending physician, stating that no blood or blood products were to be administered to her under any circumstances was a term of the contract between patient and doctor.
- [60] I need not speculate about what might have occurred at the hospital had Mrs. Hobbs declined to sign the Refusal. The fact is, the hospital insisted that the Refusal be signed as a condition of admission, it was signed, Mrs. Hobbs was admitted and the surgery was performed. Consideration was therefore provided for the Refusal which became a term of the contract between Mrs. Hobbs and Dr. Robertson. The challenge is to determine the meaning and effect of the Refusal in the tragic and sensitive circumstances of this case.
- [61] I need not be concerned with the question whether bleeding was originally caused by negligence. Whatever its cause, the bleeding could have been stopped by timely intervention and the need for transfusion would have been avoided. The negligence in this case, in respect of which liability must be determined, was the omission to intervene to stop the bleeding on a timely basis.
- (b) Interpretation of the Release
- [62] The plaintiffs submit that the Refusal was only intended to excuse Dr. Robertson from administering blood or blood products when the standard of care would have required him to transfuse in circumstances that did not result from medical negligence. They say the Refusal was not intended to excuse or waive liability in circumstances where the need for transfusion was occasioned by his negligence. The plaintiffs say that the release portion of the Refusal was designed to avoid uncertainty that might surround the meaning of the request first stated in the Refusal to the effect that no blood or blood products be transfused and should not be construed to amount to a waiver of the right to a proper standard of

medical care, whatever the circumstances.

- [63] The plaintiffs' submission is predicated on the claim that a waiver of liability for negligence must be clear and express; construing the refusal and release to waive liability for negligence would render the signatories likely to receive a lower standard of health care than those who do not sign such waivers; the care providers would not have expected Mrs. Hobbs to agree to negligent care; and contracting out of negligence in providing a service is inconsistent with the physician's duty and responsibility to his patient.
- [64] With respect, I cannot agree that the Refusal, considered in its entirety, can be given the limited effect urged by the plaintiffs. The suggestion that the release portion of the Refusal applied only in respect of the omission to transfuse blood in non-negligent circumstances cannot withstand scrutiny.
- [65] As I have previously said, in *Malette*, supra, the Ontario Court of Appeal affirmed the trial judge's conclusion that a statement made by a Jehovah's Witness that she not be administered blood or blood products compelled a physician who knew of the statement to refrain from doing so. In response to the concern that the decision placed the physician on the horns of a dilemma when treating a Jehovah's Witness in emergent circumstances, the court said the following at p. 434:

The appellant argues that to uphold the trial decision places a doctor on the horns of a dilemma, in that, on the one hand, if the doctor administers blood in this situation and saves the patient's life, the patient may hold him liable in battery while, on the other hand, if the doctor follows the patient's instructions and, as a consequence, the patient dies, the doctor may face an action by dependants alleging that, notwithstanding the card, the deceased would, if conscious, have accepted blood in the face of imminent death and the doctor was negligent in failing to administer the transfusions. In my view, that result cannot conceivably follow. The doctor cannot be held to have violated either his legal duty or professional responsibility towards the patient or the patient's dependants when he honours the Jehovah's Witness card and respects the patient's right to control her own body in accordance with the dictates of her conscience. The onus is clearly on the patient. When members of the Jehovah's Witness faith choose to carry cards intended to notify doctors and other providers of health care that they reject blood transfusions in an emergency, they must accept the consequences of their decision. Neither they nor their dependants can later be heard to say that the card did not reflect their true wishes. If harmful consequences ensue, the responsibility for those consequences is entirely theirs and not the doctor's.

- [66] Similarly, in the present case the request expressed in the first sentence of the Refusal cannot be construed to result in liability for assault and battery should a physician administer blood contrary to Mrs. Hobbs' wishes and, concurrently, to result in liability in the event of an omission to administer blood when the need for blood or blood products was not caused by negligence and the standard of care required blood to be administered. When the need for blood arose in non-negligent circumstances, the request itself, clearly and

unequivocally stated, ensured the result urged by the plaintiffs. That being the case, the release contained in the Refusal would not have been required.

- [67] An essential rule governing the interpretation of a contract is that words used by the parties be given meaning. Because of the request and its effect on liability, there is no need to provide a release from, or waiver of, liability in connection with the omission to administer blood where the need arises from non-negligent care. Were the plaintiffs' view to prevail, the release contained in the Refusal would be redundant or, as is sometimes said of phrases without meaning, mere surplusage.
- [68] The release is unrestricted in its application. It absolves the physician "from any responsibility whatsoever for unfavourable reactions or complications or any untoward results, which may include death, due to my refusal to permit the use of blood". The release 'from any responsibility whatsoever' cannot reasonably be construed to have application in some, but not all, circumstances. In addition, the plaintiffs' admit that a transfusion would have saved Mrs. Hobbs' life. In my opinion, that means her death was 'due to' her refusal to permit the administration of blood products.
- [69] The plaintiffs submit that the release should not be construed as a waiver of liability where a physician's negligence has played a part in creating the need because 'negligence' is not specifically mentioned in the text. With respect, I am not persuaded that there was any need to make specific reference to negligence in the release.
- [70] When the wording of a release is capable of application in relation to negligence, it must also be capable of application in some other circumstances if omission of a specific reference to negligence is to be a limiting factor. In *Canadian Steamship Lines Ltd. v. Regem*, [1952] 2 D.L.R. 786 (J.C.P.C.) at p. 793 the Privy Council, on appeal from the Supreme Court of Canada adopted the reasoning of Lord Greene M.R. in *Alderslade v. Hendon Laundry Ltd.*, [1945] K.B. 189 at 192, as follows:

Where the head of damage in respect of which limitation of liability is sought to be imposed by such a clause is one which rests on negligence and nothing else, the clause must be construed as extending to that head of damage, because [if it were not so construed] it would lack subject-matter. Where, on the other hand, the head of damage may be based on some other ground than that of negligence, the general principle is that the clause must be confined in its application to loss occurring through that other cause, to the exclusion of loss arising through negligence. The reason is that if a contracting party wishes in such a case to limit his liability in respect of negligence, he must do so in clear terms in the absence of which the clause is construed as relating to a liability not based on negligence.

- [71] With and without the assistance of counsel, I have been unable to identify circumstances not involving negligence in which the release would afford protection that is not otherwise afforded by the simple request that no blood or blood products be transfused. If the standard of medical practice in non-negligent circumstances required transfusion and one is excused from adherence to the standard because of the request, the only circumstances in which

there might be a dispute and need for protection and waiver are those in which there is negligence. There is no other head of damage in respect of which protection for the hospital or attending physicians and staff is required. In my opinion, that accounts for the inclusion of the release and its specific wording.

- [72] A reasonable person would be aware that any physician may, from time to time, make a mistake that amounts to negligence. It is difficult to accept that a person should be able to deny a physician the opportunity to use every tool in his or her arsenal to overcome the effects of negligence and require the physician to accept full responsibility when, as with any other patient, the effects of the negligence could have been fully ameliorated. She who is aware that blood loss may occur but is not prepared to permit transfusion, and who wishes to assert that the risk associated with blood loss is hers in the case of non-negligent treatment but that of the physician in the case of negligent treatment, should be expected to stipulate that important qualification in the direction that she signs. In this case, there is no suggestion that Mrs. Hobbs provided an uninformed refusal. There is no ambiguity in the terms of the release and the rule of construction suggesting that ambiguity should be resolved against the party drafting the document does not apply in the circumstances.
- [73] In my opinion, the deceased could not reasonably be considered to have held to the view that she assumed some part of the risk associated with the inability to transfuse blood but did not assume all of it. Notwithstanding the absence of specific reference to negligence in the release or the discussion with Dr. Suleman, the document she signed points to awareness of the risk. Awareness is reinforced by the fact that she willingly signed a document releasing specified persons 'from any responsibility whatsoever' and by her acknowledgment and acceptance in the document and in her discussion with Dr. Suleman of the fact that her inviolable request might cause her death. There is no reason why, aware as she was of what she was doing, for what reason and with what consequences, her actions should be construed to permit her estate to recover damages where others would not because life would have been saved by transfusion.

(c) Public Policy Considerations

- [74] The plaintiffs' claim that the release from liability for negligence in a medical context is void as against public policy cannot be sustained. A patient is free to direct that he or she will not accept care in the form of a specific reasonable medical treatment. Likewise, there is no reason why a patient may not agree to absolve a medical practitioner of any responsibility for negligent treatment that may cause morbidity or death particularly when the treatment that the patient wishes to prevent is the only treatment that will prevent death. I would adopt the reasoning in *Canada Trust Co. v. Ontario Human Rights Commission* (1990), 74 O.R. (2d) 481 (C.A.) in relation to the role of public policy discussed at p. 494 as follows:

Viewing this trust document as a whole, does it violate public policy? In answering that question, I am not unmindful of the adage that "public policy is an unruly horse" or of the admonition that "public policy should be invoked only in clear cases, in which the harm to the public is substantially incontestable, and does not depend on the idiosyncratic inferences of a few judicial minds": *Re Millar*, [1938] S.C.R. 1, [1938] 1 D.L.R. 65 [per Crocket J., quoting Lord Aitkin in *Fender v. Mildmay*, [1937] 3 All E.R. 402, at p. 13 S.C.R.].

[75] The plaintiffs' argument that the release of liability for negligence offends public policy appears premised on the claim that Jehovah's Witnesses will be afforded a lower standard of care than will be the case if doctors cannot be excused from negligence. There are at least three responses to the claim. First, the fact that this is the first case known to counsel in which the issue of the effect of the release in the event of death that could have been spared by transfusion has been clearly raised, suggests that Jehovah's Witnesses have been afforded the same standard of professional care physicians are obliged to provide all patients by virtue of their professional oath and ethics and their membership in and accountability to, governing professional bodies regardless of the patient's willingness or unwillingness to undergo certain types of medical treatment. To suggest that doctors would contravene their professional responsibility and provide Jehovah's Witnesses with a lower standard of care inappropriately impugns the integrity of the profession. Second, negligence is a fact of life, however regrettable the fact may be, and making a physician solely responsible for the harm associated with the inability to resort to all tools in the medical and surgical arsenal may result in Jehovah's Witnesses encountering considerable difficulty in availing themselves of the services of medical practitioners of their choice. Third, the waiver of liability for negligence here in question is very narrow. It only applies when negligence causes blood loss that must be counteracted by transfusion and the resulting morbidity or death would have been avoided by the transfusion.

(d) Volenti

[76] The defendant claims that if the defence based on contract should fail, Mrs. Hobbs should be found to have expressly assumed the physical and legal risk associated with blood loss that could not be treated by transfusion regardless of the initial cause of that blood loss. The defence is embraced by the maxim '*volenti non fit injuria*' or, 'to she who is willing, no harm is done'.

[77] The defence of volenti was described by the Supreme Court of Canada in *Car and General Insurance Corp. Ltd. v. Seymour and Maloney*, [1956] S.C.R. 322 at p.331 as follows:

a person who relies on the maxim must show that the plaintiff consented to the "particular thing being done and consented to take the risk upon himself". ...the question "is not whether the plaintiff voluntarily and rashly exposed himself to injury, but whether he agreed that, if injury should befall him, the risk was to be his and not his master's". [emphasis in original]

[78] The defence is dependent on the finding of an agreement to assume risk. The agreement may be express or it may be inferred from conduct in particular circumstances. In the absence of express agreement, the defence seldom succeeds in Canada, most likely because of the capacity to apportion fault under statutes such as the Negligence Act, R.S.B.C. 1996, c. 333. In this case, the Negligence Act was not pleaded, undoubtedly because it cannot be said that adherence to a sincerely held religious belief amounts to fault for purposes of apportioning liability. This is an 'all or nothing' case.

(i) The United States Approach

[79] Counsel urged that I might derive some assistance from two cases originating in the United States involving Jehovah's Witnesses in which the assumption of risk was discussed. The cases are *Shorter v. Drury*, 695 P. 2d 116 (Wash. 1985) and *Corlett v. Caserta* (1990), 3 A.L.R. 5th 1091. Both are instructive but ultimately not helpful in the British Columbia context.

[80] In *Shorter*, the Supreme Court of Washington, En Banc, divided 5-4 on the question before it in a wrongful death, medical malpractice action brought by the surviving family of a Jehovah's Witness. Prior to undergoing a dilation and curettage procedure, the deceased signed a refusal to permit blood transfusion worded as follows at p. 119:

I request that no blood or blood derivatives be administered to Doreen V. Shorter during this hospitalization. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatever for unfavourable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

[81] In the course of the procedure, the defendant negligently lacerated the deceased's uterus. After beginning to bleed profusely, the deceased continued to refuse to authorize a transfusion despite repeated warnings by doctors that she would likely die due to blood loss. Death ensued. The surviving husband brought a wrongful death action. He did not allege a 'survival cause of action'.

[82] A jury found the defendant negligent and determined that his negligence was 'a proximate cause' of death, but determined that the deceased 'knowingly and voluntarily' assumed the risk of bleeding to death. The jury attributed 75% of the fault for death to the refusal to accept a blood transfusion. The court did not consider the question whether the release was a term of the contract between doctor and patient.

[83] The court held that the release was not against public policy but did not absolve the defendant of responsibility for negligence because it did not specifically refer to negligence. In that regard, the law of Washington State appears to differ from that in British Columbia where, as I have stated, the absence of a specific reference to negligence need not be fatal. At the same time, the court held that there was evidence from which the jury could have concluded that the deceased and her husband understood and expressly assumed the risk of bleeding to death as a result of the defendant's negligence. The apparent inconsistency in

reasoning was picked up by the minority who expressed their bewilderment that the majority could conclude the deceased had not released the defendant from liability for negligence which the jury concluded was the proximate cause of death, but conclude at the same time that the deceased had assumed the risk of death associated with the refusal of a transfusion.

[84] The answer to the seeming contradiction may lie in the majority's reasons at p. 123:

The defendants do not argue, nor do we hold, that the Shorters assumed the risk of the "direct consequences" of Dr. Drury's negligence. Those "consequences" would be recoverable in a survival action under RCW 4.20.046, .050, and .060. Defendant argues, however, and we agree, that the Shorters could be found by the jury to have assumed the risk of death from an operation which had to be performed without blood transfusions and where blood could not be administered under any circumstances including where the doctor made what would otherwise have been [sic] correctable surgical mistake. The risk of death from a failure to receive a transfusion to which the Shorters exposed themselves was created by, and must be allocated to, the Shorters themselves.

[85] The reference to 'RCW 4.20.046' is a reference to the Revised Code of Washington State, s. 4.20.046 of which provides for the survival of actions in the following terms:

(1) All causes of action by a person or persons against another person or persons shall survive to the personal representatives of the former and against the personal representatives of the latter, whether such actions arise on contract or otherwise, and whether or not such actions would have survived at the common law or prior to the date of enactment of this section: PROVIDED, HOWEVER, That the personal representative shall only be entitled to recover damages for pain and suffering, anxiety, emotional distress, or humiliation personal to and suffered by a deceased on behalf of those beneficiaries enumerated in RCW 4.20.020, and such damages are recoverable regardless of whether or not the death was occasioned by the injury that is the basis for the action .

[86] In Shorter, the reference to the survival cause of action may have been to that for pain and suffering, anxiety and emotional distress endured before death as a consequence of medical negligence. Liability for negligence could then have co-existed with the assumption of the risk of death from the refusal to permit transfusion. If that is not the explanation, it is difficult understand the differing results reached by the majority and minority.

[87] In Corlett, a wrongful death action, the deceased had undergone surgery and began to bleed internally. The bleeding was not detected on a timely basis because of medical negligence. After the bleeding was detected, the deceased signed a refusal to accept blood and released the physician from liability for respecting and following his wishes and direction. The Appellate Court of Illinois held that under Illinois law, the direction and release did not constitute a bar to the wrongful death action as the release did not specifically exonerate the negligence that preceded the signing of the release. The court held, however, that the deceased had a duty to mitigate the damages resulting from the defendant's negligence with

the result that the award of damages would be reduced to the extent that the injuries were caused by the plaintiff's voluntary refusal of reasonable medical treatment. The court added that under principles of assumption of the risk, the award would be offset by the degree to which the plaintiff assumed the risks associated with a defendant's negligence because the plaintiff knew of the risks and nevertheless voluntarily and unreasonably proceeded to encounter them. The court reasoned as follows at p. 1100:

we believe that a physician who commits a tortious act should not be totally liable for all subsequent injuries to the patient when the patient's injuries are attributable, in part, to the patient's refusal of a proposed reasonable medical treatment. We decline to create, for a patient who refuses a reasonable life-saving medical treatment because of the patient's religious convictions, an exemption from tort principles governing mitigation of damages, comparative fault, and assumption of the risk.

(ii) The Canadian Approach

[88] The impression I gain from the United States decisions to which I was referred is that assumption of risk is a doctrine developed to co-exist with apportionment and mitigation as a means to limit recovery where negligence is involved in the maturation of a risk that cannot be contained because of a patient-imposed restriction on care. While demonstrating the approach adopted in some courts in the United States, the cases are not of assistance in the action before me because, as a general rule, assumption of risk has no independent status in Canada other than in the context of contract or conduct in relation to another's action from which it can be inferred that the claimant assumed the physical and legal risk associated with that other's conduct.

[89] In *Dubé v. Labar*, [1986] 1 S.C.R. 649 at p. 658, the Supreme Court of Canada described *volenti* in the following terms:

Thus, *volenti* will arise only where the circumstances are such that it is clear that the plaintiff, knowing of the virtually certain risk of harm, in essence bargained away his right to sue for injuries incurred as a result of any negligence on the defendant's part.

[90] Finally, in *Crocker v. Sundance Northwest Resorts Ltd.*, [1988] 1 S.C.R. 1186, the court said the following at p. 1202:

Since the *volenti* defence is a complete bar to recovery and therefore anomalous in an age of apportionment, the courts have tightly circumscribed its scope. It only applies in situations where the plaintiff has assumed both the physical and the legal risk involved in the activity.

[91] In my opinion, the law in British Columbia precludes the application of the *volenti* defence based upon an inferred rather than actual agreement in present circumstances. Mrs. Hobbs did not know with virtual certainty that harm would befall her. Such knowledge, and action by her which invited or occasioned the virtually certain harm, are at the root of the *volenti* defence. In my opinion the plaintiffs' claim fails in this case because the Refusal was a term of the doctor-patient contract, constituted an express agreement to assume risk, and

prohibited recovery when death resulted from the inability to transfuse. If the assumption of risk is not complete by virtue of a contractual term, Dr. Robertson's defence would fail and liability for the entirety of the result would ensue.

(e) Impossibility of Apportionment

[92] This is a case where negligence in the form of delayed treatment resulted in the need for transfusion and the patient's directive prohibited amelioration of the harm. In the absence of the release, equal apportionment of liability might have been considered appropriate. Regrettably, I respectfully suggest, the present state of the law would not have permitted apportionment in such circumstances and the burden of the loss would have been assumed entirely by one party or the other. I query whether that is an appropriate outcome when the adverse effects of negligence could be avoided but the opportunity to do so has been removed by a patient's deliberate decision and direction.

[93] Regardless of the result in other circumstances, the burden in this case falls entirely on the plaintiffs because Mrs. Hobbs expressly agreed to assume all risk associated with blood loss that could not be counteracted because of her refusal to accept blood or blood products by transfusion.

Damages

[94] Had it been necessary to assess damages in this case, I would have endorsed the parties' joint submission that they be assessed in the aggregate amount of \$375,000. The joint submission reflects appropriate consideration of the relevant factors in the assessment: loss of past and future financial support; loss of past and future household services; loss of guidance, care and affection; loss of inheritance; and special damages for funeral and medical expenses.

[95] The difficulty associated with the task of the assessment was described by Finch J.A., as he then was, in *Cox v. Fleming* (1995), 15 B.C.L.R. (3d) 201 at paragraph 5:

The assessment of damages under the Family Compensation Act is always difficult, and particularly so when the deceased is young and has not yet established a career, and when there is no historical record of financial contribution by him to his survivors, or of economic dependency by them upon him. When there is such a record, actuarial evidence may afford some guide as to what reasonable expectation of monetary benefit has been lost and as to its present value. The award, however, is never a matter of mathematical calculation.

[96] On the basis of the written submission of counsel on behalf of the plaintiffs, not disputed in any material respect by the defendant, I conclude that damages should be assessed as follows in the event of liability:

Jada Redlack (Mrs.Hobbs' daughter)

(a) \$23,000 for loss of past and future financial support;

- (b) \$65,000 for loss of past and future household services;
- (c) \$30,000 for loss of care, guidance, training and affection; and
- (d) \$10,000 for loss of inheritance.

Travis Redlack (Mrs. Hobbs' son)

- (a) \$33,000 for loss of past and future financial support;
- (b) \$79,000 for loss of past and future household services;
- (c) \$30,000 for loss of care, guidance training and affection; and
- (d) \$10,000 for loss of inheritance.

Caleb Hobbs (Mr. and Mrs. Hobbs' son)

- (a) \$5,000 for loss of past financial support;
- (b) \$30,000 for loss of past household services;
- (c) \$30,000 for loss of care, guidance, training and affection; and
- (d) \$10,000 for loss of inheritance.

Ernest Hobbs

- (a) \$5,000 for loss of past financial support;
- (b) \$10,000 for loss of past household services;
- (c) \$5,000 for special damages.

Disposition

[97] In the result, the action is dismissed. In the absence of agreement, the parties may speak to costs.

"I.H. Pitfield, J."

The Honourable Mr. Justice I.H. Pitfield

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